STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH SERVICES

MEDICAL REPORT

COUNTY USE ONLY	
CASE NAME:	CASE NUMBER:
WORKER NAME:	WORKER NUMBER:

SECTION I: PATIENT/CLIENT INFORMATION AND MEDICAL RELEASE

NAME OF PATIENT/CLIENT *(LAST, FIRST, MIDDLE)*
NOMBRE DEL PACIENTE/CLIENTE (APELLIDO, PRIMER NOMBRE, SEGUNDO NOMBRE)

BIRTHDATE *FECHA DE NACIMIENTO*	SOCIAL SECURITY NUMBER *NUMERO DEL SEGURO SOCIAL*	SEX *(CIRCLE)* *SEXO (PONGA UN CIRCULO)*	AGES OF CHILDREN IN HOME *EDADES DE LOS NIÑOS EN EL HOGAR*
- -	- -	M F	

I authorize/*Autorizo a* _____ of/*de* _____

(NAME OF LICENSED PHYSICIAN OR CERTIFIED PSYCHOLOGIST) *(NOMBRE DEL DOCTOR CON LICENCIA O PSICOLOGO CERTIFICADO)*

(NAME OF CLINIC OR MEDICAL GROUP) *(NOMBRE DE LA CLINICA O GRUPO MEDICO)*

to release my medical information on this form to the County Welfare Department and the California Department of Rehabilitation. This authorization is valid for one year from the date signed and I may ask for a copy of this authorization.
para que proporcione al Departamento de Bienestar Público del Condado y al Departamento de Rehabilitación de California, la información médica que se solicita en este formulario. Esta autorización es válida por un año contado a partir de la fecha de la firma y tengo derecho a solicitar una copia de esta autorización.

PATIENT/CLIENT SIGNATURE *FIRMA DEL PACIENTE/CLIENTE*	DATE/*FECHA*
▶	

SECTION II: PHYSICIAN OR LICENSED/CERTIFIED PSYCHOLOGIST INSTRUCTIONS

- **The County Welfare Department needs your information to determine if the above-named person has a physical or mental incapacity that prevents or substantially reduces the patient's ability to engage in full time work, training, and/or provide necessary care for his/her child(ren).**

Please complete the rest of this form. Explain if you need additional lab work or other exam(s) before you can determine the duration of incapacity. If you need more space, use another sheet of paper and attach it to this form.

PLEASE GIVE THIS FORM TO THE PATIENT OR RETURN IT AND/OR OTHER VERIFICATION WITHIN 5 WORKING DAYS TO:

(COUNTY STAMP)

SECTION III: PHYSICIAN OR LICENSED/CERTIFIED PSYCHOLOGIST STATEMENT

1. **Does the patient have a physical or mental incapacity that prevents or substantially reduces his/her ability to engage in work, training, and/or provide necessary care for his/her child(ren)? . . . . . ☐ YES ☐ NO**
   If "YES" (✔) ☐ Full-time ☐ Part-time
   (If "YES", complete Items 2 - 8 and Physician/Psychologist Certification. If "NO", sign and date in Certification Section.)
2. **List DIAGNOSIS and PROGNOSIS for this patient:**
   _____
   _____
   _____
3. **ONSET DATE:** _____ (MONTH, DAY, YEAR)
4. **EXPECTED DURATION:**
   ☐ Temporary, expect to release patient for
   ☐ Full-time ☐ Part-time work on _____ (MONTH, DAY, YEAR)
   ☐ Permanent
5. **DATE OF NEXT SCHEDULED APPOINTMENT** _____ (MONTH, DAY, YEAR) ☐ NONE
6. **Does patient's condition require someone to be in the home to care for him/her? ☐ YES ☐ NO**
   If YES, describe care needed (related to diagnosis):
   _____
   _____
7. **Does patient's physical/mental condition prevent or substantially reduce his/her ability to provide necessary care for the child(ren) in the home? ☐ YES ☐ NO**
8. **Describe the patient's limitations caused by this physical/mental condition:**
   _____
   _____

SECTION IV: PHYSICIAN OR PSYCHOLOGIST CERTIFICATION

- I understand that the statements I have made on this form are subject to verification and investigation for welfare fraud.
- I declare under penalty of perjury under the laws of the United States and the State of California that the information contained in this report is true, correct, and complete.

SIGNATURE OF PHYSICIAN, LICENSED CERTIFIED PSYCHOLOGIST OR PERSON AUTHORIZED TO COMPLETE FORM ▶		DATE
PRINTED NAME AND TITLE/SPECIALTY		PHONE NUMBER
STREET ADDRESS *(MAILING ADDRESS, IF DIFFERENT)*	CITY	STATE ZIP CODE